Joint Assembly and Senate Legislative Hearing:
Exploring solutions to the disproportionate impact of COVID-19 on minority communities

Testimony of the New York State Nurses Association
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May 18, 2020

Background and Context

The current economic and social crisis triggered by the coronavirus pandemic has led to mandatory shutdowns and other measures to mitigate the spread of the virus.

The public health measures taken in response to the crisis have magnified ongoing inequities in the broader economy and in the health care system. The interconnected health care and economic crises have also brought to the foreground long existing health and funding inequalities that are disproportionately impacting safety net hospitals and communities they serve.

The economic and health impact of the coronavirus pandemic most severely affect low-wage workers, immigrant communities, people of color, health care workers, and people with existing health conditions that are directly related to, caused by, or exacerbated by long standing environmental and income inequalities.

It is thus no accident that low wage workers, immigrants and people of color have higher rates of exposure, infection, hospitalization, and mortality than higher income and white populations.

These same factors also affect hospitals and other health care providers that provide a disproportionate share of care for these heavily impacted communities and populations. Again, it is no accident that the hospitals hardest hit by the wave are those that serve these communities. The public Health + Hospitals system and the private safety net hospitals.

Again, it was no accident that the epicenter of the COVID-19 crisis in New York City was the NYCHH Elmhurst hospital in Queens – it is located in a densely populated, low income, immigrant community with crowded housing conditions, large numbers of low income "essential workers"

who could not afford isolation, and who faced environmental and social determinants that made them most vulnerable to the coronavirus.

It should also be noted that the public and private safety net hospitals that are bearing the brunt of the pandemic are also perennially underfunded and under-resourced in comparison to the large academic medical private hospital systems.

The safety net hospitals have higher numbers of health care workers who are themselves people of color and more vulnerable to the pandemic. These inequalities in funding manifest themselves in many ways in the safety net hospitals: less access to personal protective equipment for both staff and patients; lower levels of staffing; shortages of equipment and necessary supplies; and ongoing lack of funding to maintain operations during the crisis.

As the health care crisis starts to stabilize in New York and reopening efforts are introduced, the economic, social and funding pressures on safety net providers and the communities they serve will intensify.

The ongoing economic crisis will lead to huge budget deficits at all levels of government, which will be particularly acute at the state and local level (due to the legal requirement to balance budgets and inability to run deficits). The highly profitable private hospital systems will receive a larger share of federal and state funding than the safety nets, notwithstanding their much more robust pre-COVID financial standing, higher revenues and surpluses, extensive accumulated assets, and easier access to private and public loan financing.

As the health crisis eases and the economic crisis comes to the fore, the large private hospital systems will likely pull down a disproportionate share of government aid, continue to pursue their own institutional strategies to increase market share of more highly reimbursed services, and increasingly avoid unprofitable services and patient populations – all at the expense of an increasingly precarious safety net system.

At the same time, safety net providers will face state and local budget cuts, increasing numbers of uninsured patients (many of whom will come from the rank of the newly unemployed who are losing their employer coverage and don't qualify for Medicaid).

The economic and health effects of the pandemic will continue for the long term and will exacerbate the long standing inequities in our economy and our health care system unless vigorous measures are taken to address the underlying structural inequities.

In this context, it is imperative that the legislature takes steps to protect the safety net hospital system – public and private, urban and rural – and the communities that rely upon them for their health services.

To that end, NYSNA makes the following recommendations:

1. Fair distribution of funding for safety net hospitals – End the "Two Tier" health system

Prior to the coronavirus pandemic, the health care safety net hospitals were already in a financially precarious condition. The public and private urban safety net hospitals provide care for a vastly

disproportionate share of uninsured and Medicaid patients, provide most of the low reimbursed services and rely most heavily on government funding to stay afloat. The rural safety net hospitals face similar disparities in funding as they provide services to poor rural communities and come under increasing pressure to close or reduce services.

The ongoing health care and economic effects of the crisis will increase the pressures on safety net hospitals and reinforce the two tier natures of our health care system – with the quality and scope of services available to our most vulnerable communities being worse than those available to more affluent populations and communities that are targeted by the large private hospital networks.

- **Fix Healthcare Funding Formulas:** Current state funding formulas for distributing DSH and ICP funding pools and Medicaid reimbursement rates continue to shortchange public and private safety net hospitals. The state must target this funding to safety net hospitals with the highest rates of uninsured and Medicaid patients. DSH and ICP monies should be exclusively focused on safety net hospitals and take into account the financial needs of hospitals. Private hospitals that have high revenues and net incomes should not receive any DSH or ICP funds. Reimbursement rates for psychiatric and chronic health conditions must be raised to meet the costs of providing this vital care. Safety net hospitals have borne the brunt of the COVID crisis, and they should receive a corresponding share of state Medicaid funding.
- **No State Budget Cuts to Healthcare and Vital Services**: The economic crisis will severely affect state and local budgets and there will be intense pressure to slash funding. The state budget for FY2021 may require cuts during the course of the fiscal year of 20-25% of health care funding. The Federal government must provide large scale grants to support state and local government spending on vital programs and to dampen the economic effect of the pandemic, including more money for unemployment insurance, expanding Medicaid or other health care coverage, food and anti-hunger programs, education, transit, and elimination of the SALT deductibility cap in the 2017 tax cuts. The state must also avoid draconian austerity cuts by finding new revenue sources from those who are most able to pay – corporations, Wall Street financial firms, billionaires and millionaires, and owners of luxury real estate.
- **Increase funding for rural and urban Enhanced Safety Net Hospitals:** The recently enacted state budget removed funding for hospitals that meet the "Enhanced Safety Net Hospital" definition in state law. The definition includes all public hospitals, designated rural sole community and critical access hospitals, and private hospitals with the highest levels of uninsured and Medicaid patients (PHL 2807-c(34)). Enhanced Safety Net Hospitals must receive the bulk of federal and state funding support to continue to operate throughout the crisis.
- **Enact a moratorium on all hospital closings:** In the last two decades New York has experienced a steady closure of hospitals and a reduction in available beds from 83,000 in 2000 to only 53,000 at the onset of the coronavirus pandemic. Many of these closures and reductions in capacity occurred in underserved areas and affected low income communities. The COVID-19 crisis clearly revealed the need to maintain safety net hospital infrastructure. The state must impose a moratorium on further closures. In addition, the process for approving closures must be strengthened to provide for community input and a strict determination of community needs before any hospitals are closed or services are reduced in future.
- **Penalize wasteful executive pay and non-patient care spending:** Many private hospital net-works are operated in a manner that is increasingly indistinguishable from the activity of private for-profit corporations. These hospitals pay exorbitant salaries to their CEOs and scores of top executives, spend inordinate amounts of money on advertising and marketing, and focus entirely on increasing market share (of the most lucrative patients and health services) and

increasing net revenues. In taking this approach, they are motivated more by profits and expanding their power than they are on enhancing the public's health. State funding and reimbursement policies should be adjusted to prohibit or claw-back excessive management compensation and non-patient care expenditures.

- **Expand the role of public hospitals and pubic health care infrastructure**
  In New York City the Health + Hospitals system is the backbone of the entire health care system. It has about 20% of all in-patient beds, provides the most Level I trauma center capacity, provides a disproportionate number of out-patient and primary care clinic services, and provides an increasing and disproportionate share of in-patient and out-patient mental health, emergency department services, and treatment for chronic health conditions. The hardest hit communities during the COVID-19 crisis relied on NYCHH facilities such as Elmhurst, Lincoln and Kings County for their care. In fact, while Elmhurst was facing "apocalyptic" conditions in late March and early April, there were thousands of beds in nearby hospitals that were empty. The public hospital system must be expanded and play a leading role in the ongoing response to the pandemic and must receive the funding and resources to fulfill this vital role. This must include redistribution of funding from the profitable private hospital systems to the public hospitals and private safety net hospitals.

2. Emergency action to address racial, class and social disparities and inequities

NYSNA has historically focused on highlighting and addressing long-standing disparities in care within our health care system. Poor, working class, minority and immigrant communities have poorer health outcomes and less access to care, live in areas that subject them to dangerous or unhealthy environmental factors, and rely on under-resourced safety net hospitals and other health care providers. These factors contribute to worse health outcomes than wealthier communities.

The ongoing pandemic and the parallel economic crisis have highlighted and intensified these long-standing structural inequities in the health care system. According to statistics produced by the City of New York, for example, the infection, hospitalization and mortality rates for people of color are much higher than for white populations. The COVID-19 mortality rate for black New Yorkers, for example, is more than double that of whites. Similar patterns have been revealed across the country. People of color, immigrants, and low wage workers in "essential" businesses have been exposed to, contracted, and died from COVID-19 at rates that are grossly disproportional to their share of the population.

It is clear that the devastating effect of the pandemic on these communities is directly tied to the historic inequities in our economic and health care structures. Communities confronted with low paying jobs, sub-standard housing, more polluted and contaminated neighborhoods, relative lack of access to healthier foods, underfunded health care services and outright discrimination had poorer health coming into this crisis. It should come as no surprise that the pandemic has severely affected these already vulnerable communities and populations.

- **Addressing disparities in health services must be a top state priority**
  The state and local governments must focus on providing more funding and infrastructure to provide vital health services in communities that have been subject to historical inequities.
- **Addressing social determinants of health**

The lop-sided impact of the pandemic on vulnerable communities requires a concerted effort to address underlying social determinants of health, including expansion of housing support, stepped up efforts to correct environmental contamination and address the impact of climate change, provision of culturally and linguistically sensitive basic services, increased wages and benefits for low income workers, improved transportation services, better access to educational resources for students and adults learners, availability of green spaces, and increased access to sports and exercise programs. These efforts to address social determinants of health must be closely linked to the funding and improved infrastructure of safety net hospitals and providers.

- **Expanded health care services for immigrant populations**
  Immigrant populations, particularly undocumented immigrants, must be guaranteed access to needed health care services regardless of ability of pay. Currently, the NYC Health + Hospitals system and other safety net hospitals provide the bulk of services to the uninsured. The large private hospitals networks must be compelled to contribute a greater share of these vital services or be made to pay a financial penalty to support the safety net providers that currently should this burden. All hospitals must be required to provide full and ongoing health services to any patient regardless of insurance coverage or lack of ability to pay.
- **Addressing COVID's Racial Disparities**
  African Americans and Latinos at dying from COVID-19 at twice the rate of white New Yorkers, reflecting decades of neglect and inequitable distribution of government services and economic investment. Reversing these longstanding inequalities must be a central focus as we move forward, and state lawmakers must prioritize funding for significant healthcare infrastructure, income support and services to the hardest hit communities.
- **Everyone In, Nobody Ou*t***: With over a million New Yorkers out of work we need to make sure every New Yorker can get the care they need during this pandemic. The New York Health Act would provide universal healthcare for everyone in the state, and lawmakers must take the first steps in that direction by paying for all COVID-related healthcare costs for unemployed, uninsured, underinsured, or undocumented New Yorkers.
- **Expand Paid Sick Leave Benefits to Low Wage and Essential Workers**
  The ability to take time off from work if a worker is sick is critical to that health of the worker and her family, but also to protecting the rest of the community from exposure to COVID-19. Federal and state legislation enacted in response to the crisis has expanded the right of workers to take paid sick leave, but it does not go far enough. The legislature must expand existing sick leave benefits to apply to all employers. This is vital to addressing the disparate impact on vulnerable communities.
- **Expand Low Income Housing Programs**
  A major contributing factor to the disparate impact of COVID-19 on low income communities is the poor quality of housing and lack of space for self-isolating to protect vulnerable household members. The state should embark on a long-term program to provide expanded housing support in low income communities. In the short term, special housing should be provided and made available to COVID positive patients who do not have viable access to appropriate isolation space in their home to protect seniors and family members with co-morbidities.
- **Reduce environmental pollution and contamination of our air, water, soil and food supplies**
  There is a direct correlation between polluted environments in low income neighborhoods and poorer health outcome. The State must undertake a sustained effort to improve the quality of the air, water and food quality in all neighborhoods and end the racial disparities that have long plagued poorer communities.

3. Reopening – Recovery Panning

As the state and localities move to reduce lock-downs and gradually reopen the economy, it is imperative that steps are taken to protect the communities and low income workers that will bear the brunt of the increased risks of exposure and illness.

To that end, NYSNA recommends that following measures to protect vulnerable communities and workers:

- **Universal Testing**: Frontline health workers and essential workers have tended to be disproportionately people of color and low wage workers. As we reopen, it is imperative that all essential workers and vulnerable communities receive on-demand rapid-result testing. Testing resources must in addition be targeted to communities of color, immigrant communities and low income communities.
- **Avoid Abusing Anti-Body Testing**: Antibody tests cannot be used to send workers back to work in unsafe conditions or to require them to work without adequate protective gear.
- **Adequate PPE**: The reopening of the economy must include the production, stockpiling and fair distribution of protective equipment for health care facilities, workplaces and households. Every hospital in the state must return to conventional capacity guidelines and begin the transition to reusable rather than disposable PPE. Stockpiles must be built up, so healthcare workers aren't left unprotected during the next outbreak. Essential workers must also be protected. In addition, there must also be adequate and proper PPE for transit workers, factory workers, grocery clerks, retail staff, restaurant workers, delivery drivers and all other workers. The state must take an active role in centralizing, funding and coordinating the acquisition, stockpiling and distribution of PPE to hospitals and other providers based on local needs.